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The Efficacy of St. Francis Halfway House Residential Treatment Services for Adults Diagnosed with Borderline Personality Disorder

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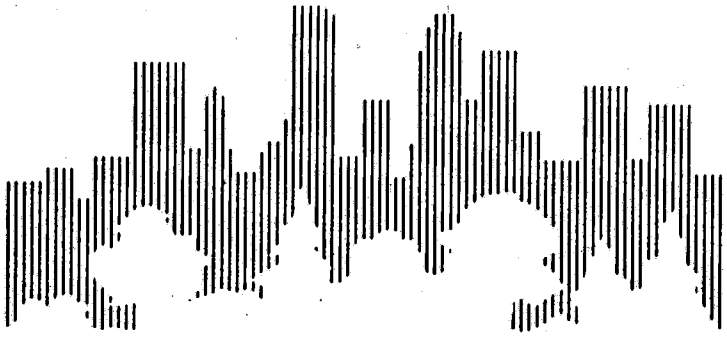

C • O • L • L • E • G • E

MASTERS IN SOCIAL WORK THESIS

Teri Dimond

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1996

ABSTRACT OF THESIS

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The Efficacy of St. Francis Halfway House Residential Treatment Services for Adults Diagnosed with Borderline Personality Disorder

by
Teri Dimond

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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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This thesis is dedicated to Chad Anthony Erickson.

T.D.D.

ABSTRACT OF THESIS

Borderline Personality Disorder is difficult to treat, and diagnosed more prevalently in women. Individuals with this mental disorder are treated in a number of ways in Minnesota, including residential treatment services. This comparative study examines the effectivenes of residential treatment services for adults diagnosed with Borderline Personality Disorder at St. Francis Halfway House. In studying the effectiveness of this treatment modality, two variables; discharge to a less restrictive environment, and with staff approval, are explored to determine treatment success.

TABLE OF CONTENTS

VI. APPENDIXES

LIST OF TABLES

I. INTRODUCTION

Definition of the Problem

According to Johnson (1988), "Borderline clients are widely regarded as being difficult and frustrating to work with because of characteristics such as intense hostile-dependent feelings toward the practitioner, overidealization of the social worker alternating with rageful disappointment, suicidal or otherwise violent behaviors, impulsivity and recklessness, transient lapses into psychosis, and the tendency to terminate treatment abruptly" (p. 166).

The diagnosis of Borderline Personality Disorder has attracted wide attention among social workers, since almost every social work setting includes individuals who meet diagnostic criteria for Borderline Personality Disorder (Gunderson, 1984). Individuals with characteristics of Borderline Personality Disorder often present themselves to mental health providers with problems such as substance abuse, suicidal ideation/gestures, family violence, eating disorders, reckless spending, and other problems of self-control (Johnson, 1988).

This research was an exploratory study that examined the effectiveness of the St. Francis Halfway

House residential treatment program in rehabilitating adults diagnosed with Borderline Personality Disorder. To determine the effectiveness of residential treatment services, resident statistical information was retrieved from the Woodland Centers computer system and analyzed. Discharge results of the population diagnosed with Borderline Personality Disorder was compared to the remaining population diagnosed with a Serious and Persistent Mental Illness to determine St. Francis Halfway House program effectiveness.

Research Question

Is St. Francis Halfway House residential treatment services effective in rehabilitating adults diagnosed with Borderline Personality Disorder.

Importance of the Study

Individuals diagnosed with Borderline Personality Disorder may receive psychiatric rehabilitative services within a residential treatment environment. Therefore, a study exploring the effectiveness of residential treatment would present greater insight to mental health providers in recommending this treatment modality to individual clients and their families. In

addition, this writer began employment with Woodland Centers in January 1995, and felt this study would offer findings that would be of value to Woodland Centers--St. Francis Halfway House in assisting with further program development and implementation.

Background Information

The writer obtained the data used in this study from statistical information stored within the Woodland Centers computer system. Information on all individuals receiving treatment services from Woodland Centers was obtained at admission and then again at discharge. Computerized information for the current study was retrieved on all seventeen residents discharged in 1994.

Limitations of the Study

The scope of the following study was limited to the results obtained from computer generated statistical information on a relatively small sample who have received treatment at St. Francis Halfway House. For comparison purposes, a larger sample would have been preferable.

This study used a problem that could have been expanded for more extensive consideration. This study group represents a small segment of the total St. Francis Halfway House population who have received treatment in 1994.

In addition, this study does not control such extraneous variables--treatment success could be dependent on medication compliance, willingness to actively participate, and/or family involvement.

Since this study was done as part of the graduate work in the Master's of Social Work program at Augsburg College, it had to be completed within a defined time frame. Time constriction prohibited the inclusion of additional aspects in the methodology that could have provided additional information or support for the findings.

Conceptual Framework: Medical Model

Due to insurance reimbursement and allocation of county/state matching monies to fund mental health residential treatment programs, an individual's diagnosis has been the focus for determination of eligibility for funded services. The medical model refers to the concept of diagnosing symptoms and

prescribing a form of treatment. Within the mental health field, the DSM-III-R (manual used in 1994 by clinicians, however DSM-IV was being introduced) provides criteria that assists with the diagnosis of a mental disorder. Within the St. Francis Halfway House program an individual must have a diagnosed mental disorder that requires treatment within a residential treatment program.

Definition Of Terms

St. Francis Halfway House Program

St. Francis Halfway House is a residential treatment facility located in rural Atwater, MN. St. Francis Halfway House is a component of Woodland Centers, a comprehensive mental health center.

In Minnesota, residential treatment is licensed by the Department of Health and the Department of Human Services under Rule 36. Rule 36 is defined as "a planned combination of living conditions and mental health programming for the rehabilitation of five or more adults diagnosed with a serious and persistent mental illness at one time for more than thirty days in any twelve month period and on a twenty-four hour per

day basis" (MN Statute, section 245A.02, subdivision 14).

Eligibility criteria were established by the state of Minnesota, to serve "serious and persistently" mentally ill adults, who were deemed to be most in need of community-based mental health services, including residential treatment (Minnesota Comprehensive Adult Mental Health Act, 1991). (See Appendix I for State Mandated Eligibility Guidelines.) With the development of community-based mental health services, residential treatment has become a treatment service option for adults diagnosed with Borderline Personality Disorder.

According to the 1993 St. Francis Halfway House annual report, "St. Francis strives to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs;

(2) help clients achieve the highest level of independent living;

(3) help clients gain necessary skills to function in a less structured setting; and

(4) stabilize crisis admissions" (page 1).

The population served at St. Francis Halfway House includes adult male and female individuals diagnosed with a serious and persistent mental illness who are in

need of transitional and supportive residential care with a primary focus on rehabilitation and activities of daily living. Rehabilitation activities of living are designed to assist the residents in regaining and/or maintaining the highest level of functioning possible for them. The goal of this focus is to assure that the residents are living in the least restrictive living environment possible for their current level of functioning. (See Appendix II, for St. Francis Halfway House Admission Criteria.)

Usually, St. Francis Halfway House residents have had prior inpatient treatment in a state regional treatment center and/or community psychiatric hospital. Priority for placement is given to residents from the Woodland Center's six county service area. (See Appendix III, for Catchment Service Area.) Non-residents are accepted on the basis of placement agreements and the utilization of the Kandiyohi host county contracts.

Length of stay is determined by resident need, with authorization from financially responsible counties.

Residential Treatment Services

Residential treatment services will be defined in this study as one or more mental health services provided while residing within St. Francis Halfway House program. Services may include supportive counseling, case management, independent living skills training, medication education/administration, leisure skill development, vocational skill development, and crisis intervention. (See Appendix IV, for St. Francis Halfway House Program Services.) Intensity of service is based upon individual need and is provided by trained professionals.

Treatment Effectiveness

Treatment effectiveness was determined upon examining two variables 1.) "Successful discharge" and 2.) discharge with Staff Approval. "Successful discharge" was identified by discharge to a less restrictive community situation (placement with less than twenty-four hour supervision). Staff approval was identified when a client, upon discharge, had achieved seventy per cent or better with stated goals within their individualized treatment plan, and had received a

recommendation for discharge from their St. Francis Halfway House Mental Health Counselor.

Adult

Adult refers to both men and women age eighteen years or older.

Borderline Personality Disorder

Borderline Personality Disorder is one of eleven Axis II personality disorders listed within the 1987 Diagnostic and Statistical Manual Revised, a diagnostic tool used to diagnose mental disorders. Minnesota's Mental Health Comprehensive Act (1991), requires recipients of county funded mental health services must be diagnosed by a master's level or higher human service professional who has had at least two years supervised experience. The person to be served must have been diagnosed within twelve months prior to receiving St. Francis Halfway House residential treatment. Borderline personality disorder qualifies as one of the four "serious and persistent" mental disorders, making that diagnosis eligible for Rule 36 placement.

According to the American Psychiatric Association's DSM-III-R (1987), "Borderline Personality Disorder is a pervasive pattern of instability of mood, interpersonal relationships, and self-image; beginning by early adulthood and present in a variety of contexts," as indicated by at least five of the following:

1) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation

2) Impulsiveness in at least two area that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior)

3) Affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days

4) Inappropriate, intense anger and lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights

5) Recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior

6) Marked and persistent identity disturbance manifested by uncertainty about at least two of the following; self-image, sexual orientation, long-

term goals or career choice, type of friends desired, preferred values

7) Chronic feelings of emptiness or boredom

8) Frantic efforts to avoid real or imagined abandonment" (p. 194).

Serious and Persistent Mental Illness

For the purpose of this study, this term refers to all individuals who are not diagnosed as having Borderline Personality Disorder who were receiving services from St. Francis Halfway House.

Willmar Regional Treatment Center

Refers to the State psychiatric Hospital located in Willmar, Minnesota.

II. REVIEW OF LITERATURE

The literature review completed for this thesis was achieved through computerized research methods. The key words used in the literature search were: mental illness, borderline personality disorder, dissociative disorders, abuse, psychiatric hospitalization, residential treatment, and mental health policy.

Review of Mental Health Policy

During much of the first half of this century, large state hospitals were generally regarded as the best way to treat adults diagnosed with a mental illness. Attitudes changed dramatically in the 1950's and 1960's and a belief developed that the mentally ill would fare better outside state institutions (Isaac and Armat, 1990).

During the last thirty-five years, a number of powerful legal, medical and social forces have combined to produce a dramatic decline in the number of public psychiatric hospital beds and have increased the need for less restrictive community placement options. The Joint Commission on Mental Health and Illness in the late 1950's recommended against building any more state

hospitals and argued for the system of care that ultimately became the community mental health system. In 1963, Congress passed the Community Mental Health Centers Act, which allocated federal funding for the construction of comprehensive community-based mental health centers. Subsequent legislation, enacted in 1965, expanded federal financial support to cover community mental health center operations (Kennedy 1990).

With the discovery and use of psychotropic medications in the 1950's, psychiatric patients were more able to manage within the community, hence contributing to the move toward deinstitutionalization (Keisler, 1992). The community mental health movement, which emerged in the 1960's, advocated locating mental health services as close to the patient's home as possible (Anthony et al., 1990). It was believed that this would ease the transition from institutional to community life and promote family involvement in the treatment process (Johnson, 1990). Public psychiatric hospitals, which were often located in rural areas and away from patients' families, violated this established philosophical view. Therefore, moving patients from these institutions to their communities became a major

issue in deinstitutionalization. The large-scale release of state hospitalized psychiatric patients stimulated the development of a range of community psychiatric residential treatment options such as transitional half-way houses (Isaac and Armat, 1990).

In response to the deinstitutionalization movement, Minnesota required that by February 1974, county boards had to provide or contract for enough residential treatment services to meet the needs of all adults diagnosed with a mental illness residing in every county and needing this level of care (MN Department of Public Welfare, 1982).

Etiology of Borderline Personality Disorder

Historically the diagnosis of Borderline Personality Disorder represents an effort to describe an individual who demonstrates a specific pathological personality organization (Jacobson, 1979). According to Kernberg (1967) the characteristics of this disorder includes specific traits and is not merely a transitory state between neurosis and psychosis (Kernberg, 1967). In fact, because persistent instability is characteristic of individuals diagnosed with Borderline

Personality Disorder, they were described as being "stably unstable" (Schmideberg, 1959).

According to Johnson (1988), "Almost all observers agree that interacting biological and environmental factors play a role in the development of the borderline personality disorder" (p. 167). Literature indicates developmental, biological, and environmental factors as contributing to the etiology of Borderline Personality Disorder, however controversy exists about which aspects environmental, developmental, or biological, are most important. The majority of more recent research has indicated that there are serious developmental traumas (childhood abuse) experienced by people diagnosed with Borderline Personality Disorder (Sederer, 1986). However, contemporary literature still has not found any apparent single pattern.

Epidemiology of Borderline Personality Disorder

No accurate incidence, prevalence, and socio-economic figures are available on Borderline Personality Disorder, particularly since diagnostic validity and reliability are still being established. The disorder appears to be more common in women and established by adolescence or earlier (Sederer, 1986).

Gunderson (1984), estimated that fifteen per cent of the overall population have diagnosable characteristics of Borderline Personality Disorder.

Prevalence tends to increase with the intensity of the treatment setting (Swartz et al., 1990). In outpatient settings, individuals receiving treatment for Borderline Personality Disorder are estimated to represent eleven per cent of all outpatients (Widiger & Frances, 1989). In contrast, among inpatients rates vary between nineteen and twenty-three per cent (Widiger & Frances, 1989). The overall community prevalence rate of Borderline Personality Disorder is two to four per cent (Gunderson & Zanarini, 1987).

The Chestnut Lodge Study (McGlashan, 1984) eighteen per cent of their residential treatment program population were diagnosed with Borderline Personality Disorder. Stone (1986), reports that Borderline Personality Disorder is diagnosed more frequently in females than in males, with ratios estimated between 2:1 and 3:1. In treatment settings, seventy to seventy-five per cent of those with a diagnosis of Borderline Personality Disorder were female (Widiger & Frances, 1989). Persons diagnosed with Borderline Personality Disorder tend to be younger

and the diagnosis is rarely made in older patients (age 30), which may be a function of a decrease in symptoms later in life (Paris et al., 1987).

Treatment Outcome

Evidence that could explain relative effectiveness of in-patient or residential treatment approaches had been limited to a very small number of studies. Such documentation on treatment outcome comes from two sources: a long-term retrospective follow-up study of patients diagnosed with Borderline Personality Disorder who spent time in the New York State Psychiatric Institute (Stone, 1987) and the Chestnut Lodge Study (McGlashan, 1986).

A study by Linehan provides a prospective, partially randomized study comparing outpatient behavioral treatment with other community-based treatment approaches (Linehan et. al., 1989).

New York State Psychiatric Institute Study

In a study conducted at the New York State Psychiatric Institute, 254 borderline patients were evaluated ten to twenty-three years after discharge from the hospital (Stone, 1987). Most had shown

serious self-destructive tendencies at the time of admission. At follow-up, forty per cent were rated as recovered using the Global Assessment Scale (Spitzer et al., 1979), attaining scores greater than seventy. They also discovered the recovery process often had required five to ten years of treatment. Two-thirds of the patients had a good or very good outcome (scores greater than sixty).

Stone (1987) reported that for all patients, supportive psychoanalytic (individual and group) interventions were important to bring about significant improvement. However, only about one-third of the hospitalized patients with Borderline Personality Disorder were agreeable to psychoanalytic therapy. In addition, among the one-third who showed some benefit from insight-oriented treatment, dramatic benefits took place only for those who were generally likable by others, motivated, psychologically minded, focused, free of overwhelming impulsivity and substance craving, and not from "grotesquely destructive" early environments (Stone,1987). Many patients improved in functioning when functional assessments were conducted again, but gravitated toward different treatment

strategies and different types of therapists following discharge.

Effects of therapy could not be compared systematically with effects of no treatment. However, several patients diagnosed with Borderline Personality Disorder left the psychiatric institute against medical advice soon after the three months required for inclusion in the study. Many recovered with no intensive therapy and no aftercare. In these cases, recovery was attributed to effective containment during the critical self-destructive phase and the patients' innate powers of recuperation related to personal assets such as courage, perseverance, and industriousness. Some patients became alcoholics after leaving the institute, had several difficult years, then joined Alcoholic Anonymous and improved steadily (Stone, 1987).

Chestnut Lodge Study

Chestnut Lodge is a small, private psychiatric hospital in Rockville, Maryland, specializing in the long-term residential treatment of patients diagnosed with psychotic and Borderline Personality Disorders. In another major retrospective study done at Chestnut

Lodge, data did not permit conclusions related to differences in treatment methods, but according to the researchers the data were useful for estimating long-term prognosis (McGlashan, 1986).

McGlashan (1986) completed a follow-up study on the long-term outcome of patients with Borderline Personality Disorder residing at Chestnut Lodge. Research findings indicated that the average length of stay for the population diagnosed with Borderline Personality Disorder was twenty-six months. Slightly more than half of the patients with Borderline Personality Disorder studied (forty-three out of eighty-one) were rated "good" or "recovered" on ratings of functioning done on a follow-up averaging fifteen years post discharge; about one-fifth (seventeen people) were rated "poor" or "marginal," with the remainder in between. A high intelligence quotient and the absence of frequently shifting unstable mood were strongly related to better outcome (McGlashan, 1986).

Overall conclusions about individuals diagnosed with Borderline Personality Disorder who are impaired enough to be hospitalized, based on both these studies, are that one-half to two-thirds have a good long-term prognosis. The psychiatric institute study indicates

that supportive treatment is important for all, whereas intensive insight-orientated psychotherapy is beneficial for a small subset with high intelligence and motivation who are culturally orientated and who do not have severe impairments (Stone, 1987 and McGlashan, 1986).

Linehan Study

In a comparative study of the effectiveness of outpatient behavioral treatment versus other approaches (Linehan et al., (1989), twenty-eight subjects, all women who had a history of repeated parasuicidal behavior and who also met criteria for Borderline Personality Disorder, were assigned by a partial randomization method to a behavioral treatment group or to another community treatment group they chose to engage in. Parasuicidal behavior was defined as any intentional, acute, self-injurious act resulting in actual tissue damage, illness, or risk of death, or ingestion of drugs or other substances not prescribed or in excess of prescribed dosage with clear intent to cause bodily harm (Linehan et al., 1989).

The behavior treatment group continued for approximately one year with combined weekly individual

sessions and weekly group treatment sessions. This behavioral treatment method emphasized problem solving. The conduct of the therapist was guided by an explicit, detailed manual of procedures. In addition to weekly individual and group sessions, subjects made regular phone calls to the therapist between sessions as part of the treatment plan.

Participants were assessed using a developed level of functioning scale tool before treatment, then four months and eight months into treatment, and again post treatment. Although women who received behavior therapy did not report greater improvement in subjective experiences of depression than women receiving other community treatments, they showed significantly reduced suicidal behavior when compared with control subjects. Behavior therapy patients were less likely to be parasuicidal at all during a single time period. In addition, behavior therapy patients reported fewer parasuicidal episodes throughout the entire study. When parasuicidal behavior did occur, it was usually less severe that of control patients who received other forms of treatment (Linehan et al., 1989).

However, it was not possible to determine to what extent positive outcomes were due to behavioral methods and to what extent the combination of intensive ongoing psychoeducational group treatment with individual treatment accounted for the patients' improvement. The evidence strongly supported the efficacy of combination treatment (individual behavioral therapy and psychoeducational group treatment) in reducing parasuicidal behavior Linehan et al., 1989).

III. METHODOLOGY

In order to obtain data regarding the effectiveness of residential treatment services offered by St. Francis Halfway House in treating adults diagnosed with Borderline Personality Disorder, a computer search was completed. All individuals receiving services from St. Francis Halfway House in 1994 were included in this study.

Research Design

A comparative study was used to determine treatment effectiveness of the St. Francis Halfway House program. A comparison study was selected as the entire 1994 population were involved in and received the same residential services. The entire sample was anonymous--using only client numbers to retrieve information in order to protect confidentiality.

The two study groups were identified as follows: Individuals diagnosed with Borderline Personality Disorder, regardless of other diagnoses, were place in one group, with the remaining population placed within the Serious and Persistent group. Two variables; discharge to a lesser restrictive environment and staff approval of discharge, were used as measures to compare

and establish the effectiveness of St. Francis Halfway House program services in rehabilitating adults diagnosed with Borderline Personality Disorder. Both criteria, discharge to a lesser restrictive environment and staff approval, must have been met to be calculated as a successful discharge.

In the process of gathering data to answer the research question, computer generated statistical information along with admission/discharge data collection forms were reviewed to identify the individuals within the Borderline Personality Disorder population from the total 1994 St. Francis Halfway House population.

Subject Selection

The rationale for the selection of all 1994 discharged St. Francis Halfway House subjects was that in order to determine treatment effectiveness, a number of cases needed to be identified to offer meaningful comparison groups.

Data Collection Source

The data for this study was gathered by reviewing staff compiled admission/discharge information that

included the total 1994 discharge population, diagnosis, discharge placement, and staff approval. (See Appendix V and VI, for Program Data Collection Instruments.)

Instrument Design

For individuals receiving services from Woodland Centers, data are collected at admission and then again at discharge. Information is coded, assigned a client number, and stored within the Woodland Centers computer system.

Information obtained at admission includes: date of admission, diagnosis, age, sex, and legal status of the client. Information obtained at time of discharge includes: date of discharge, treatment involvement, discharge situation, and staff approval.

Computerized statistical admission/discharge information was requested from the Woodland Corporations' computer system. Names of individuals admitted and discharged from St. Francis Halfway House in 1994 were not associated with data obtained; therefore, only pertinent information, without client names, was requested and reviewed.

IV. PRESENTATION OF FINDINGS

This chapter presents a summary of the data analysis of Woodland Centers, St. Francis Halfway House information, obtained through a computer search of records. The study considers the following aspects: (1) resident background information; (2) status of admittance; (3) treatment involvement; and, (4) treatment effectiveness.

Resident Background Information

For this study, background characteristics of the residents include; the identification of resident population by admittance diagnosis, and the age and sex of the discharged resident population in 1994.

Admission Diagnosis

As noted in Table I, seven, or 41.2 per cent, of the residents discharged in 1994 were diagnosed as Borderline Personality Disorder at time of admission. Ten, or 58.8 per cent, were admitted with a diagnosis of Seriously and Persistently Mentally Ill without a diagnosis of Borderline Personality Disorder.

TABLE I
Admission Diagnosis

Delineation	# of Residents	Percentage N=17
BPD	7	41.2
SPMI	10	58.8
Totals	17	100.0

TABLE II
Age of Study Population

Age	BPD	SPMI	Percentage N=17
18	1	0	5.9
19	0	1	5.9
20	1	0	5.9
22	1	0	5.9
28	1	1	11.7
29	1	0	5.9
30	0	1	5.9
33	2	1	7.5
35	0	1	5.9
37	0	1	5.9
39	0	1	5.9
43	0	1	5.9
45	0	1	5.9
51	0	1	5.9
Totals	7	10	100.0

Age of Study Population

Table II, indicates that the mode and median age of the residents studied was thirty-three years, with the mean age being 31.9 years. The writer found it interesting to note that all seven, 100 per cent, of the population diagnosed with Borderline Personality fell within the age group of eighteen to thirty-three, while only four, or 40 per cent, of the population diagnosed Serious and Persistent Mentally Ill fell within that age bracket.

TABLE III
Sex of Study Population

Sex	BPD	SPMI	Percentage N=17
Male	1	6	41.2
Female	6	4	58.8
Totals	7	10	100.0

Sex of the Study Population

As shown in Table III, ten, or 58.8 per cent, of the residents were female. Seven, or 41.2 per cent, were male.

It is interesting to note that the sex of the population diagnosed as having Serious and Persistent Mentally Illness was split nearly equally with six, or 60 per cent, male and four, or 40 per cent, female. However, the population diagnosed as having Borderline Personality Disorder indicated a predominate female, six, or 85.7 per cent.

Status of Admission

For the purpose of this study, the writer considered whether residents were admitted to the program at St. Francis Halfway House on a voluntary or court ordered commitment basis.

TABLE IV
Status of Admission

Status	BPD	SPMI	Percentage N=17
Voluntary	1	7	47.1
Committed	6	3	52.9
Totals	7	10	100.0

Table IV, indicates that eight, or 47.1 per cent, of the residents studied entered treatment voluntarily. Nine, or 52.9 per cent, received treatment following a court ordered commitment.

Of the SPMI population, seven, or 70 per cent, received treatment on a voluntary basis. Three, or 30 per cent, were committed to treatment following a court order.

In contrast, however, six, or 85.7 per cent, of the individuals diagnosed Borderline Personality Disorder had received treatment after a court ordered commitment, while only one, or 14.3 per cent, had voluntarily entered the program for treatment.

Treatment Involvement

This section is devoted to a presentation of the findings concerning the specialized treatment services received by the residents during their stay at St. Francis Halfway House. It consider the following elements: type of treatment received and the number of days in treatment.

Type of Treatment Received

As shown on Table V, twelve, or 70.1 per cent, of the total study population received partial hospitalization treatment consisting of structured group therapy provided by mental health professionals at the Woodland Centers. Therapeutic services included group counseling, medication education and consultation, symptom education and management training, nutrition education, occupational skill and life skill development, and recreation/leisure skill development training. Six, or 85.7 per cent, of the individuals diagnosed Borderline Personality Disorder residents received partial hospitalization programming while six, or 60 per cent of the remaining Serious and Persistent Mentally Ill population did.

Table V
Type of Treatment Received

Treatment	BPD	SPMI	Percentage N=17
Psychotherapy	3	4	41.2
Partial Hospitalization	6	6	70.1
Employment	2	7	52.9
Chemical Dependency		1	5.9
Education		2	11.8
Other	1	1	11.8

*Many of the residents received multiple treatments for their psychiatric disabilities.

Nine, or 52.9 per cent, of the residents were either employed competitively or through supportive vocational programming within the community. Two, or 28.6 per cent, of the population diagnosed Borderline Personality Disorder were employed, whereas, seven, or 70 per cent, of the population diagnosed Serious and Persistent participated in vocational programming.

Psychotherapy by licensed mental health professionals was received by seven, or 41.2 per cent of the study population. Three, or 42.9 per cent, of the population diagnosed as Borderline Personality participated in psychotherapy, whereas four, or 40 per cent, of the population diagnosed Seriously and Persistently Mentally Ill received such services.

Two, or 20 per cent, of the Serious and Persistent group participated in educational programs. One Serious and Persistent Mentally Ill resident was treated for Chemical Dependency. Many of the study population received multiple treatments for their psychiatric disabilities and two, or 11.8 per cent, left the program before goals could be established.

Number of Days in Residential Treatment

As illustrated in Table VI, four, or 23.5 per cent of the total study population received either less than fifty, or between 201 to 300 days of residential treatment, respectively. Six, or 35.2 per cent received between fifty-one and 100 days residential treatment, while only three, or 17.8 per cent, received more than 300 days. The writer noted that the majority of the group diagnosed Borderline Personality Disorder had relatively short-term residential treatment stays, while inversely, the group of Serious and Persistent Mentally ill indicated much longer residential treatment duration.

TABLE VI
Number of Days in Residential Treatment

Number of Days	BPD	SPMI	Percentage N=17
1-50	3	1	23.5
51-100	1	2	17.6
101-200	1	2	17.6
201-300	2	2	23.5
301-400		1	5.9
over 400		2	11.9
Totals	7	10	100.0

The total number of days in residential treatment by the Borderline Personality Disorder group was 752. The mean number of days was 107.4, while the median number was 54 days.

In contrast, the total number of days the Serious and Persistent Mentally Ill group remained in residential treatment was 2387. The mean number of days these residents received residential treatment was 238.7 and the median number was 202 days.

Treatment Effectiveness

For the purpose of this paper, treatment effectiveness be evaluated on 70 per cent participation in specialized treatment programming with staff approval at the time of discharge, and discharge to a lesser restrictive environment.

Staff Approval Upon Discharge

As illustrated in Table VII, it was noted that sixteen, or 94.1 per cent, of the halfway house residents and all of the Borderline Personality group were discharged with staff approval.

TABLE VII
Staff Approval Upon Discharge

Staff Approval	BPD	SPMI	Percentage N=17
Yes	7	9	94.1
No	0	1	5.9
Totals	7	10	100.0

However, it should be noted that four of the study group (two individuals diagnosed Borderline Personality Disorder and two individuals diagnosed Serious and Persistent) were approved for discharge to the Willmar Regional Treatment Center as it was felt they could benefit from the greater degree of structure available there. One individual diagnosed Serious and Persistent was not approved for discharge when he chose to return to his home state to be with his family.

Discharge Placement Arrangement

This section is devoted to a presentation of the findings concerning successful discharge. Successful discharge is defined as a discharge to a lesser restrictive environment (less than 24 hour double-coverage staff supervision), and including staff approval at the time of discharge.

Table VIII, page 39, provides a summary of the placement arrangements for the residents upon discharged from St. Francis Halfway House in 1994. Of the total population studied, seven, or 41.2 per cent, were discharged to their own apartments. Two, or 11.8 per cent, returned to their families and three, or 17.6 per cent entered a less supervised Rule 36 treatment facility.

Four, or 23.5 per cent, of the residents were transferred to the Willmar Regional Treatment Center for more structured programming and one resident was transferred to the Detention Center in Sauk Center.

Of the population diagnosed Borderline Personality Disorder, four, or 57.1 per cent, returned to their apartment or families. Two, or 28.5 per cent, were transferred to the Willmar Regional Treatment Center and one was transferred to the Detention Center.

Of the Serious and Persistent group, five, or 50 per cent, returned to their apartments or families. Two, or 20 per cent, were referred to Willmar Regional Treatment Center and three, or 30 per cent, entered Category II, less supervised, Rule 36 treatment facilities.

TABLE VIII
Discharge Placement Arrangement

Placement	BPD	SPMI	Percentage N=17
Less Restrictive			
Family	1	1	11.8
Apartment	3	4	41.2
Category II, Rule 36	0	3	17.6
More Restrictive			
WRTC	2	2	23.5
Detention Center	1	0	5.9
Totals	7	10	100.0

Treatment Success

Table IX, records the success of treatment experienced by the study population. A majority of the residents, or 64.7 per cent, found success in their treatment as indicated by their discharge records. Only six, or 35.3 per cent, did not experience success.

TABLE IX
Treatment Success

Success	BPD	SPMI	Percentage N=17
Yes	4	7	64.7
No	3	3	35.3
Totals	7	10	100.0

Four individuals from the Borderline Personality group, or 57.1 per cent, left treatment with staff approval for a less restrictive environment. Three individuals diagnosed Borderline Personality Disorder, or 42.9 per cent, entered more restrictive environments with staff approval, and therefore, are not considered as treatment successes for the St. Francis Halfway House in 1994. Among the Serious and Persistent group, seven, or 70 per cent, left treatment with staff approval for a less restrictive environment. Two individuals within the Serious and Persistent Mentally Ill group, or 20 per cent, entered more restrictive environments with staff approval and one client entered a less restrictive environment without staff approval. The latter three residents would not be considered as treatment successes based on the limitations within this study.

V. DISCUSSION

The purpose of this chapter is to present a summary of the findings, conclusions and recommendations, based upon the data presented in the study.

Summary of Findings and Recommendations

A summary of the principal findings concerning the relative effectiveness of the St. Francis Halfway House residential treatment program in rehabilitating adults diagnosed with Borderline Personality Disorder in 1994 are as follows:

The residents of St. Francis Halfway House were found to be relatively young, with the mean age being 31.9 years. The population diagnosed as Borderline Personality Disorder were considerably younger than the remaining Serious and Persistent Mentally Ill population.

The Borderline Personality Disorder population was predominately female, whereas the Serious and Persistent Mentally Ill population was predominately male.

The vast majority of the Borderline Personality Disorder population received residential treatment

services under the direction of a court commitment, while most of the Serious and Persistent Mentally Ill population participated in residential treatment voluntarily. The Borderline Personality Disorder population required more structured psychotherapeutic services than did the Serious and Persistent Mentally Ill population who were found to participate more frequently in vocational rehabilitative services. Therefore residential treatment providers should seek voluntary admissions of individuals diagnosed with Borderline Personality Disorder, to ensure that they will be motivated to actively participate in the treatment services offered.

The staff of St. Francis Halfway House nearly always approved discharge of residents. However, often the discharge was to a more restrictive environment. Due to program staff offering discharge recommendations, training should be made available to staff employed in residential treatment programs on the issues surrounding the successful treatment of individuals diagnosed with Borderline Personality.

The Borderline Personality Disorder population received one-half the number of residential treatment days as compared to the Serious and Persistent Mentally

Ill population. St. Francis Halfway House was more successful in the placement of the Serious and Persistent Mentally Ill group in less restrictive environments with staff approval than it is with the population diagnosed Borderline Personality Disorder. Therefore, residential treatment programs should encourage individuals diagnosed with Borderline Personality Disorder to participate in educational and vocational training to a greater extent, to ensure increased skill development in preparation for community living. In addition, residential treatment programs should develop and implement more restrictive screening procedures, to ensure residents are capable of complying to residential treatment expectations.

Periodic follow-up surveys of this study should be made in order to evaluate the on-going effectiveness of residential treatment services, while encouraging further program development.

It is the writer's hope that the information compiled herein will be used to strengthen and expand the already valuable services of Woodland Centers, St. Francis Halfway House.

MINNESOTA COMPREHENSIVE
MENTAL HEALTH ACT. 1991. Sec. 245.461 to 245.486, Subd. 20.

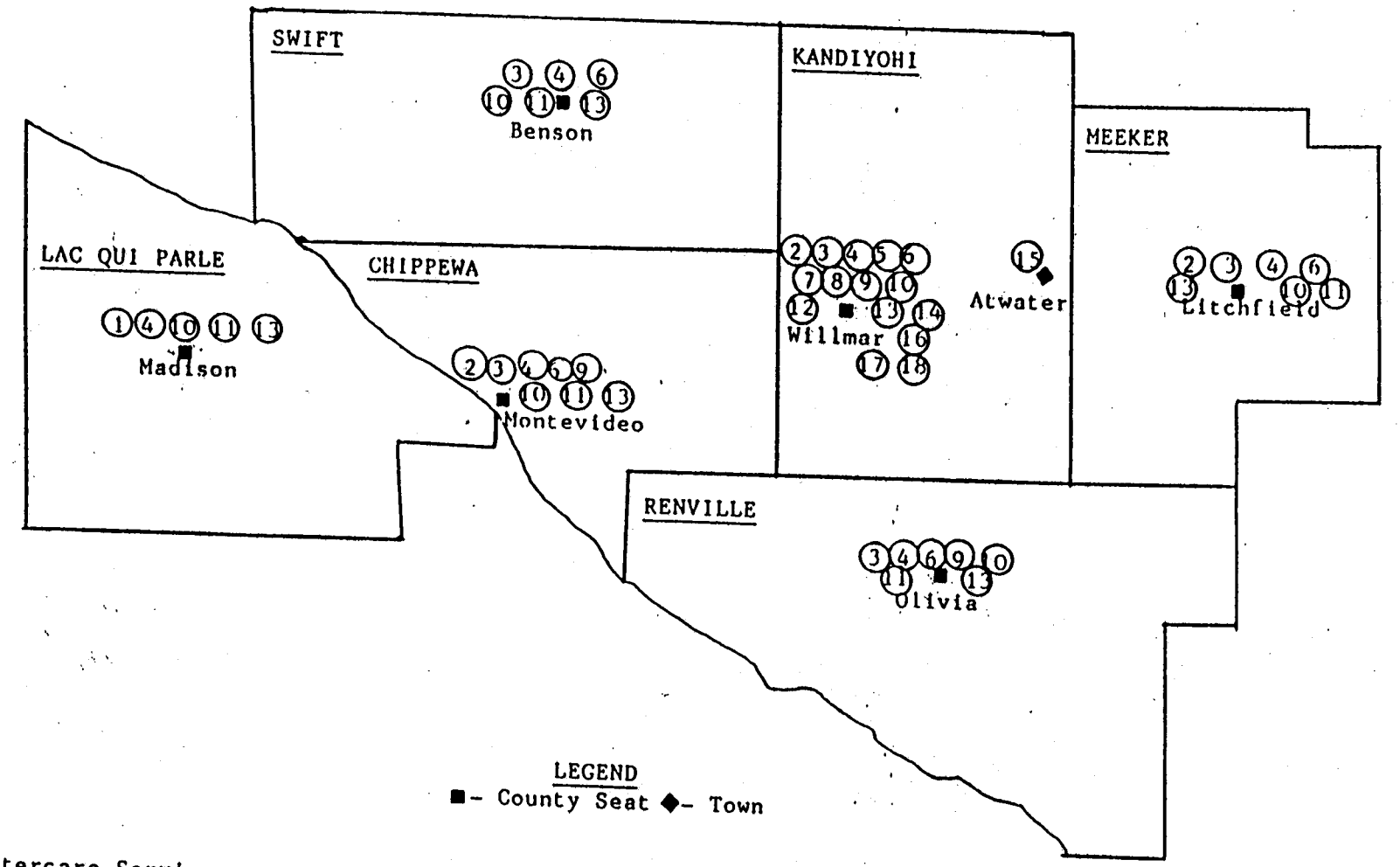
person with "Serious and Persistent Mental Illness" means a person who as a mental illness and meets at least one of the following criteria:

(1) the person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months.
(2) the person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
(3) the person:
(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;
(ii) indicates a significant impairment in functioning; and
(iii) has a written opinion from a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or
(4) the person has been committed by a court as a mentally ill person under chapter 253B, or the person's commitment has been stayed or continued.

lental illness" means an organic disorder of the brain or a clinically gnificant disorder of thought, mood, perception, orientation, memory, or havior that is listed in the clinical manual of the International Classiation of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 306.0 to 316.0 or, the corresponding code in the American Psychiatric sociation's Diagnostic and Statistical Manual of Mental Disorders SM-MD), current edition, Axes I, II, or III, and that seriously limits a rson's capacity to function in primary aspects of daily living such as rsonal relations, living arrangments, work, and recreation.

WEST CENTRAL COMMUNITY SERVICES CENTER, INC.

Service Area and Service Sites



1. Aftercare Services
2. Audiology Services
3. Community Support Program
4. Consultation & Education
5. Crisis Intervention Program
6. Day Treatment
7. Detoxification Center
8. DWI School
9. Elderly Day Services
10. Emergency Services
11. Field Outreach Clinics
12. Inpatient Services
13. Outpatient Services
14. Outpatient Primary Chemical Dependency Treatment Program
15. Saint Francis Halfway House
16. Sexual Abuse Treatment
17. Shelter House
18. Temporary Residence

APPENDIX II
St. Francis Halfway House. (1993). Annual Report. Woodland Centers.

APPENDIX III

Program Services

St. Francis Halfway House. (1993). —

Annual Report. Woodland Centers

The following services are offered either by Woodland Centers (WC), St. Francis Halfway House (SFHH) or through a working agreement with other community resources:

A. Case management services: These services are provided by the County Family Service Agencies of the client's residing county. Internal case management is coordinated by the Unit Director of SFHH with input from the individual staff members.

B. Crisis services: These services are provided by the Crisis Unit/Temporary Residence of WC. When necessary, clients are admitted to the Regional treatment Center.

C. Independent living skills training: These services are provided primarily by the staff of SFHH. Additional training is provided through Day Treatment Programming of WC and through Lutheran Social Services.

D. Mental health therapy: These services are provided primarily by professional staff members of WC, in individual and group situations. The client may be referred to outside agencies and individuals as necessary in special cases.

E. Motivation and remotivation services: These services are provided jointly by staff of SFHH and WC.

F. Recreation and leisure time services: These services are provided jointly by staff of SFHH and WC.

G. Socialization services: These services are provided jointly by the staff of SFHH and WC.

H. Support group services: These services are provided jointly by the staff of SFHH and WC. A weekly support group is held for the clients at SFHH by a Mental Health Counselor.

I. Social services: These services are provided by the client's county of residence.

J. Vocational services: These services are provided as needed on an individual basis through the local colleges, high school services, West Central Industries, and vocational preparation at WC. Clients are referred to Department of Rehabilitation Services as needs are identified.

K. Other services: As needs are identified, SFHH attempts to connect the client with the appropriate resource, e.g. referral to chemical dependency and special support groups.

(These are further explained in first section under "Units of Service")

APPENDIX IV

WOODLAND CENTERS
St. Francis House. (1993)
Annual Report. Woodland Centers.

Admission Criteria:

Individuals prior to placement at St. Francis House are screened for appropriateness.

Criteria for admission are:

1. Applicants must be 18 years or older.

2. Applicants must have a diagnosed "Serious and Persistent" mental illness, and residential treatment is recognized as necessary for rehabilitation.

3. Applicants must be physically and mentally capable of participating in the program and having a willingness to work and establish treatment goals with a realistic goal of eventual discharge to a lesser restrictive community living situation.

4. Applicants must be able to abstain from physically assaultive, self-injurious, suicidal, and chemical abusive behaviors.

5. Applicants must have financial resources to cover the cost of placement.

T CENTRAL COMMUNITY SERVICES CENTER Appendix V

Application for Services

☐☐☐ CL NO. ☐☐-☐☐-☐☐ ADM DATE ☐☐ EPU ☐☐☐ ST COMPLETED BY_____

. NAME: _____
LAST FIRST M.I. OTHER NAMES

ENT ADDRESS: _____
NO. AND STREET OR ROUTE TOWN/CITY STATE ZIP COUNTY

ANENT ADDRESS: _____
NO. AND STREET OR ROUTE TOWN/CITY STATE ZIP COUNTY

'HONE: Home: ____/____-- _____ Work: ____/____-- _____ Employer: _____
AREA CODE AREA CODE

SE OF
GENCY NOTIFY: _____
IG WITH YOU) NAME/RELATIONSHIP STREET/TOWN/STATE PHONE NO.

'BIRTH: _____ SSN: _____

1☐ Male 2☐ Female VETERAN: 1☐ Yes 2☐ No

ATION: (Highest grade completed) _____

1☐ White 2☐ Black 3☐ Am. Indian 4☐ Asian 6☐ Other_____ (specify)

NIC ORIGIN: 1☐ Yes 2☐ No

AL STATUS: 1☐ Single, never married 2☐ Married
4☐ Divorced 5☐ Separated 6☐ Widowed

ENTIAL ARRANGEMENT: 1☐ Private home/apt. ☐ Other_____

ARRANGEMENT:

Relative(s)

Non-related person(s)

LEGAL STATUS:
1☐ Voluntary
2☐ Involuntary Civil
3☐ Involuntary Criminal

RY:
Previous MH/CD Treatment: 1☐ Yes 2☐ No
Within Past Year: 1☐ Yes 2☐ No
By WCCSC: 1☐ Yes 2☐ No

NTING PROBLEM: (Check up to 3 that apply)

1☐ Marital/Family
2☐ Social/Interpersonal
3☐ Coping with daily roles
4☐ Medical/Somatic
5☐ Depression/Mood Disorder
6☐ Alcohol
7☐ Drugs
8☐ Attempt, threat, danger of suicide
9☐ Involvement with criminal justice
10☐ Eating Disorder
11☐ Thought Disorder
12☐ Abuse/assault/rape victim
13☐ Runaway Behavior
☐ Other_____

re under 18 years of age:

ime (or legal guardian's) _____

nployer _____

ed:

se's name _____

lace of employment _____

EFERRED YOU TO WCCSC: ☐☐☐☐ Referral Code

] Self 2☐ Family/friend ☐ Other(specify) _____

YMENT STATUS:

mployed 3☐ Full time student 5☐ Retired 7☐ Not applicable (under 18)

omemaker 4☐ Disabled 6☐ Unemployed

SOURCES OF FAMILY INCOME (Mark ALL which apply):

93☐ Earnings 95☐ Unemployment
94☐ Social Security ☐ Public Assistance (County)_____
96☐ Retirement Pension 97☐ Other _____

SSI/SSDI ELIGIBILITY DETERMINATION:

1☐ Eligible, Receiving Payments 4☐ Determined Ineligible
2☐ Eligible, Not Receiving Payments 5☐ Not Applicable
3☐ Potentially Eligible

Responsible Party for Payment:

Name: _____

Address: _____

_____

Telephone: _____ SSN: _____

Insurance Company:

Name: _____

Address: _____

Policy: _____ Group: _____

Contract #: _____ Policy Holder: _____

Medicare #: _____

Medical Assistance #: _____

Coverage Dates: From _____ to _____

TO BE COMPLETED IF VERIFICATION OF INCOME PROVIDED:

Gross family income of $_____ ☐ annually ☐ monthly ☐ weekly

and family size of _____ was verified by _____ this date.

CLIENT AUTHORIZATION FOR 3RD PARTY CLAIMS:

I request that payment for services received from West Central Community Services Center (WCCSC) be made directly to WCCSC. I authorize WCCSC to release to the aforementioned 3rd Party Payor(s) diagnosis, dates, type and provider of service(s) regarding myself and/or my dependent(s) for purposes of processing a claim. This authorization expires one year from the date signed. I understand that I may revoke my consent at any time except to the extent that WCCSC has already disclosed data.

_____ _____
SIGNATURE OF POLICYHOLDER DATE

I, THE UNDERSIGNED, CONFIRM THAT --

I am requesting services. I have received a copy of The Data Privacy Statement. My Responsibilities and Rights and the How Do I Pay for Services brochure.

I AM FINANCIALLY RESPONSIBLE FOR MY BILL.

I understand that if I am a resident of Chippewa, Kandiyohi, Lac qui Parle, Meeker, Renville or Swift Counties, that I may apply for a reduced fee. In order to do so, I must provide information on my family size and verification of my gross income within 30 days from today; and if I do not, I will pay the full bill immediately.

SIGNATURE OF CLIENT OR LEGAL GUARDIAN: _____

CLIENT INFORMATION AT DISCHARGE

Provider ID: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

A. Client ID: |_|_|_|_|_|_|_|_|_|_|_|_|_|_| B. Date of Discharge __|__|__| mm dd yy

C. Reason for Discharge

80 Discharged with Staff Agreement
90 Acutely MI-Hospitalization Required
91 Discontinued Due to Problem Behavior
71 Client Decided to Leave Without Staff Agreement
73 Services not continued due to joint/ resident staff decision to discontinue
92 Lost Financial Support
93 Initially assessed as more appropriate for other program and referred
94 Deceased (specify cause: _____)
95 Other (specify): _____
_____
_____

D. Living Arrangements At Discharge

82 Jail/Correctional Facility
73 State Hospital
90 Other Hospital Psychiatric Unit
65 Nursing Home
87 R 36 Respite adm from hospital
88 R 36 Respite adm from non-hospital
89 Fairweather Training Center or Tasks Lodge
63 Other category I Program
64 Other category II Facility
42 Rule 35 Facility
21 Adult Foster Home
05 Parent's Home
03 Other Relatives' Home
68 Spvd. Apt. Living (e.g., Vail Place, Kosciolak House)
61 Non-36 B&C
62 Non-36 B&L
04 Own Home/Apt.
01 Transient
99 Other (specify): _____

E. Psychiatric Hospitalization while in program:

Hospital Setting	# of Times	# of Days
State or VA Hospialization:	__	___
Other psychiatric Hospital:	__	___

F. Vocational Status at Discharge

06 Work Activity/Skills Trng Prog.(e.g.,VPS)
12 Volunteer Work
80 Fairweather Training Center/Fairweather Ward
07 Other Job Training Program (e.g., Vail Place, RISE)
81 Tasks Lodge
82 Part-Time Sheltered Emp. (less than 32 hrs/wk)
83 Full-Time Sheltered Emp. (32 hrs. or more/wk)
26 Supported Competitive/Transitional Employment
08 Occasional Employment (e.g., Labor Pools)
01 Part-Time Competitive Employment (less than 32 hrs/wk)
02 Full-Time Competitive Employment (32 hrs or more/wk)
84 High School Program
85 Vocational School Program
86 College Program
09 Homemaker (resp. for least 2-person household)
11 Retired
10 Unemployed (if none of the above)

WEST CENTRAL COMMUNITY SERVICES CENTER
INSTITUTIONAL REVIEW BOARD

DATE: 2/9/95

NAME: Teri Dimond

PROJECT TITLE: The effectiveness of St. Francis Halfway House residential treatment services in treating adults diagnosed with Borderline Personality Disorder

The above-referenced project was reviewed by the Institutional Review Board on _____, and the following action was taken:

_____ Project approved.
Next scheduled review is on _____.

__X__ Project approved. **EXEMPT CATEGORY** No. 2. No periodic review scheduled unless so stated in REMARKS SECTION.

_____ Project approval deferred.
(See REMARKS SECTION for further information.)

_____ Project denied.
(See REMARKS SECTION for further information.)

REMARKS: Any changes in protocol or adverse occurrences in the course of the research project must be reported immediately to the IRB chairperson.

Kathleen M. Sloan PhD 2/10/95

Signature of Chairperson or designated IRB Member **Date**
WCCSC's Institutional Review Board

If the proposed project (clinical medical) is to be part of a research activity funded by a Federal Agency, a special assurance statement or a completed 596 Form may be required.

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